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ABSTRACT

This report outlines the Bridgeport Futures Initiative, a collaborative project undertaken in 1990 by health, education, and social service organizations in Bridgeport, Connecticut, to improve the lives and educational outcomes of children and youth. The report discusses the origins of the initiative, as well as the cross-systems co-location case management model used to provide education, health, and human services to families in need. It also discusses the Strategic Intervention for High Risk Youth program, which is designed to provide prevention and intervention programs for young adolescents at risk of involvement with drugs and drug-related crime. The report includes a copy of the first annual "Bridgeport Report Card on the State of Our Children," which presents: (1) a demographic profile of children in Bridgeport and patterns of service utilization; (2) information on child and youth substance abuse, teenage pregnancy and health, education, and youth employment; and (3) the goals of the Bridgeport Oversight Collaborative to improve the lives of children and youth. (Contains 38 references.) (MDM)

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BRIDGEPORT Futures INITIATIVE

A Collaborative on Behalf of Youth

PS 022134

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VISION

Bridgeport's vision for its children ...

We believe that every child can learn, and that every child should be healthy and safe.

Therefore, we make the commitment to provide every young person in Bridgeport with every opportunity to be healthy and to grow into competent and caring adulthood.

...and for the adults responsible for making this vision a reality...

We believe that the entire Bridgeport community should share responsibility for the well-being and success of every child.

Therefore, we make the commitment that every child will be provided with the tools she/he needs to be successful, and that we will be held publicly accountable for our efforts to do so.

MISSION

To provide the means by which all diverse constituencies in the Bridgeport community can work together collaboratively to:

- *reduce the rates of teen pregnancy, drug/alcohol dependency, high school dropouts and youth unemployment problems which threaten the future of too many of Bridgeport's young people.*
- *continuously widen the scope of community awareness and understanding of these youth problems.*
- *identify the weaknesses, service delivery gaps and policy or funding barriers in youth-serving institutions which, if eliminated, would increase the likelihood that every child can be successful.*
- *mobilize the entire community and other regional and statewide resources to take action and make necessary changes in youth-serving institutions.*
- *develop Bridgeport's permanent capacity and commitment to respond to problems by taking collaborative action; and*
- *report publicly on the community's progress in achieving positive youth outcomes.*

BRIDGEPORT Futures INITIATIVE

A Collaborative on Behalf of Youth

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BRIDGEPORT Futures INITIATIVE

A Collaborative on Behalf of Youth

LEAD AGENCY
University of Bridgeport

OVERSIGHT COLLABORATIVE
Michael E. Schrader
Chairman

Brenda J. Smith
President

FACT SHEET

HISTORY:

In February 1987 in response to the challenge posed by the Annie E. Casey Foundation, the City of Bridgeport initiated a planning and problem solving process that resulted in the Bridgeport Futures Initiative. Bringing together a cross-section of the community, the Initiative worked at identifying a comprehensive approach to the complex problems facing at-risk youth. As a result, Bridgeport received an innovation grant of $750,000 over three years. In 1990, Casey named Bridgeport a fully funded New Futures city with a five year grant of $5 million.

MISSION:

To provide the means by which all diverse constituencies in the Bridgeport community can work together collaboratively to improve life outcomes for children and their families.

OVERARCHING GOAL:

To create the conditions for child/youth success by bringing about lasting changes in policies, practices and funding which now stand as barriers to positive life outcomes for children.

COLLABORATORS:

Schools, health and human service agencies, government, parents, businesses, higher education and children.

FUNDERS:

The Annie E. Casey Foundation
Peoples Bank
General Electric
State Department of Children and Families
Center on Addiction and Substance Abuse at Columbia University
United States Bureau of Justice Assistance
Office of Justice Programs

STRATEGY:

The Futures Institute for Systems Change, a comprehensive multi-sector, child-oriented institute for education and training, consultation and technical assistance and applied research and policy studies. Mechanisms such as a Services Providers Roundtable of social and health service providers, and community forums will further the ways that collaboration can improve the lives of youth.

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BRIDGEPORT FUTURES INITIATIVE
FACT SHEET

Mission

To provide the means by which all diverse constituencies in the Bridgeport community can work together collaboratively to reduce: rates of teen pregnancy, drug and alcohol dependency, high school dropout and youth unemployment problems which threaten the futures of too many of Bridgeport's young people.

Primary Activities

Using the collective strenghts, talents and resources of the partners participating to manage and facilitate the change process by:

- Conducting research;
- Strategically using information;
- Developing leadership throughout the community, including parents, children, agencies and institutions
- Advocating change;
- Facilitating systems integration;
- Modeling collaborative behavior;
- Convening the change makers; and
- Proposing to the Oversight collaboration responses which have the greatest potential for positive impact for children.

Major Accomplishments

During 1990 under the leadership of the Oversight Collaborative, thousands of children were touched by a Futures-related initiative. Programs and activities were undertaken in a collaborative manner by four lead agencies and two major staff initiative and services were delivered through subcontracts with community providers. As a result of this collaborative process, attendance rates at the three target schools has increased significantly and parental involvement with the Parent Education and Support Committee has increased with more parents involved in daily activities at the schools. Until implementation of the Futures Curriculum and Human Sexuality Mini-Series, the need or factual up-to-date information on health and sexuality was unmet. The Co-location Case Management Team (a network of key social service institutions) continues to collaborate on the delivery of services to students and families in the South End community.

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Collaborative Members/Partners

Bridgeport Board of Education
City of Bridgeport
State Departments of Human Resources, Health Services and Children and Youth Service
The Bridgeport Regional Business Council
The Greater Bridgeport Adolescent pregnancy Program
The Regional Youth/Adult Substance Abuse Project
Parents, Teachers and the Community

How Long in Existence

The Initiative began as an innovation of city for the Annie E. Casey Foundation in 1987, and has since expanded to a fully funded city.

Governance and Staff Structure

The Initiative is governed by an Oversight Collaborative, consisting of a cross section of members from State Departments of Human Resources, Health Services and Children and Youth Services, the Board of Education, parents, and key members of the community.

Number of Staff

The staff includes and Executive Director, a Parent Education and Support Director, a Case Management Director, a Case Management Systems Manager, and Education Initiative Liaison, a Teen Dropout Prevention/Employment Liaison, and a Teen Pregnancy/Health Liaison.

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A Collaborative on Behalf of Youth

BRIDGEPORT FUTURES CROSS-SYSTEMS C0-LOCATION CASE MANAGEMENT MODEL:

AN INTRODUCTION

ELIMINATE THE BARRIERS
AND FAMILIES WILL SUCCEED

P8

BRIDGEPORT FUTURES INITIATIVE

CASE MANAGEMENT MODEL

VISION

Futures Case Management Model was initiated in 1990.

Futures Case Management Co-location Model is an approach based on a set of principles that transcend program guidelines set by categorical funding. The ethical standards set forth call for decisions based on principle rather than expediency.

The ultimate goal for case management is self management, recognizing that the greatest service provided is the opportunity to express our unique capacities, to have a decent income and join with our fellow citizens in creating productive communities.

The human service delivery system thrives on problem solving by experts and systems while diminishing problem solving capacities of citizens and communities.

Futures Case Management Model must serve as a bridge between a community encouraged to depend on human services to a self sufficient productive community.

Caught in the middle of these two realities, Futures is working in the realm of the human service delivery system while promoting a service approach that respects and upholds the basic dignity, capacity and worth of every human being.

For this end the Co-location Model was developed. The principles of the Co-location Model are reflected in the interagency agreement and standards for a comprehensive service delivery system.

PRIMARY FEATURES OF FUTURES CASE MANAGEMENT MODEL

I FAMILY MENTORS

The role of the Family Mentors attempts to demonstrate the need for agency staff working directly with youth and families to be empowered to structure their work activities in response to the families instead of programmatic guidelines and limitations.

II INTERAGENCY/INTERDISCIPLINARY TEAM

The Co-location Team serves as a forum for interagency communication that provides an effective mechanism for pooling agency and human resources, for service coordination and integration that offers child centered, family focused comprehensive services.

III DOCUMENTATION OF BARRIERS

The design of the Co-location Model includes plans for a comprehensive management information system that can be use to track and document gaps in service and barriers.

1993/94 WORKPLAN HIGHLIGHTS

- Futures will continue to promote and strengthen the Co-location Model as a vehicle for interagency service delivery by continuing to implement SIHRY, CASSP and other innovative working relationships that build upon existing service collaborative efforts for youth and families.

- In partnership with the Bridgeport Housing Authority (BHA), the Bridgeport Department of Police and all the participant agencies of the Case Management Model, the Co-location Model will be tested as a neighborhood based interagency service delivery system in selected public housing sites.

- Training and networking opportunities will be offered to all agency line staff workers and parents.

- Tracking and documentation of service gaps and barriers will be captured in periodic reports to be addressed to Oversight Collaborative members from the perspectives of case managers, youth and parents.

- To pursue untapped funding sources for case management services like medicaid reimbursement and the Department of Children and Families' discretionary funds for wraparound services, and to establish financing mechanisms to access such resources.

STANDARDS
FOR

COMPREHENSIVE SERVICE DELIVERY SYSTEM

A Comprehensive Service Delivery System offers an expanded scope of flexible prevention, treatment, and support services that may be tailored and packaged to meet the multiplicity of interrelated needs unique to each youth and family.

Provides indefinite involvement on a continuous basis responding to reoccurring crisis situations of the youth and family, as the way to self-sufficiency is patiently paved.

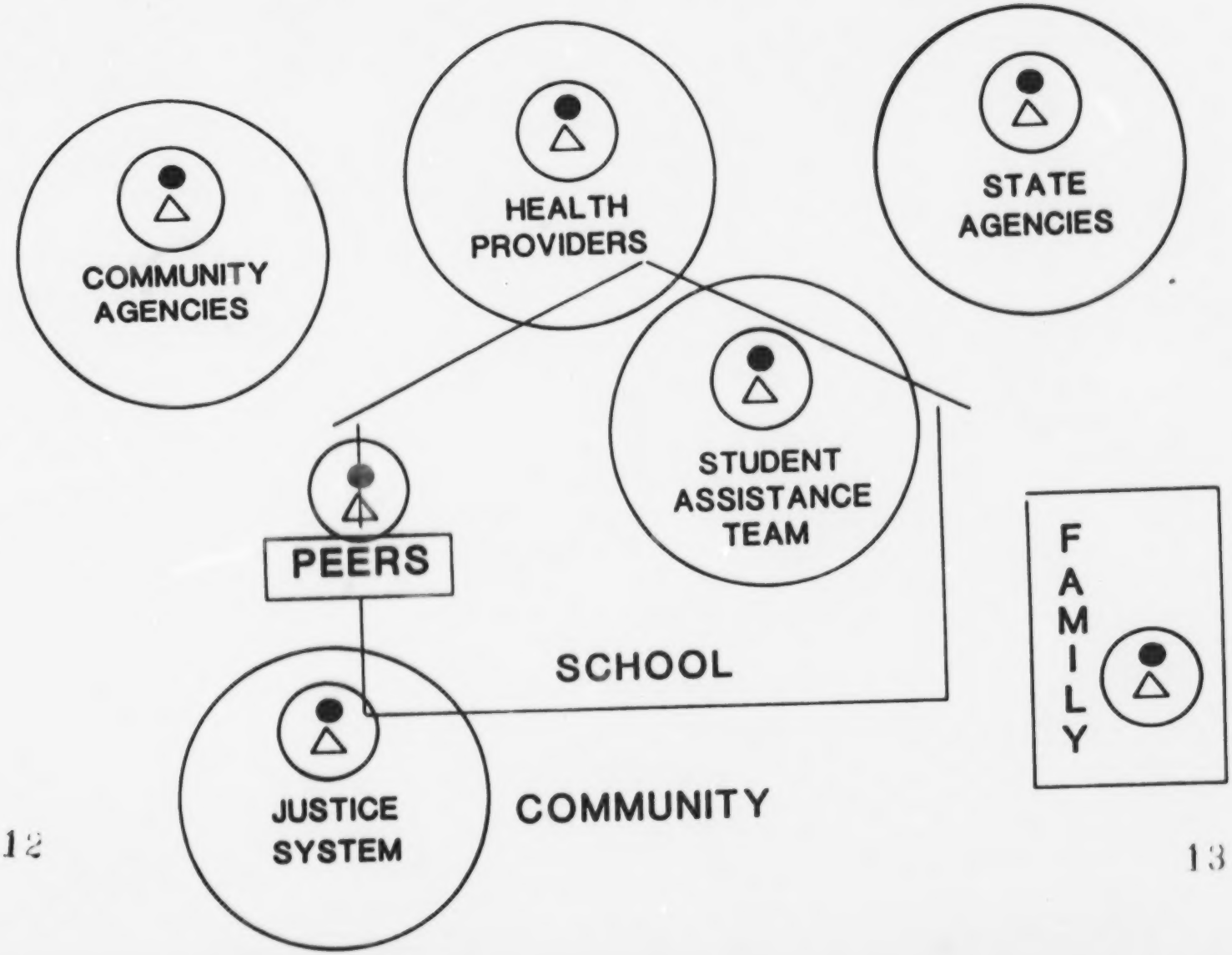
The delivery system is organized to eliminate gaps through using proven strategies, such as interagency agreements, co-location of staff, and joint case management, to maintain a continuum of services, ongoing follow up, and communication between providers and the youth and family.

Serves the whole family recognizing that problems confronting other household members, especially parents, often affect their children.

Fosters mutual respect by considering the culture, values, priorities, and desires of the youth and family allowing for self-direction in the joint identification of needs and solutions.

Develops an evaluation designed to continously measure progress toward the achievement of ageed-upon indicators of success for both individual youth and families, as well as the community atlarge.

Develops a management information system to collect data on needs, services available, service gaps and barriers, impact of services, and uses data to develop relational analysis, and advocate for adjustments anywhere from an individual service plan, to the way services are delivered and funded.


COMMUNITY AGENCIES
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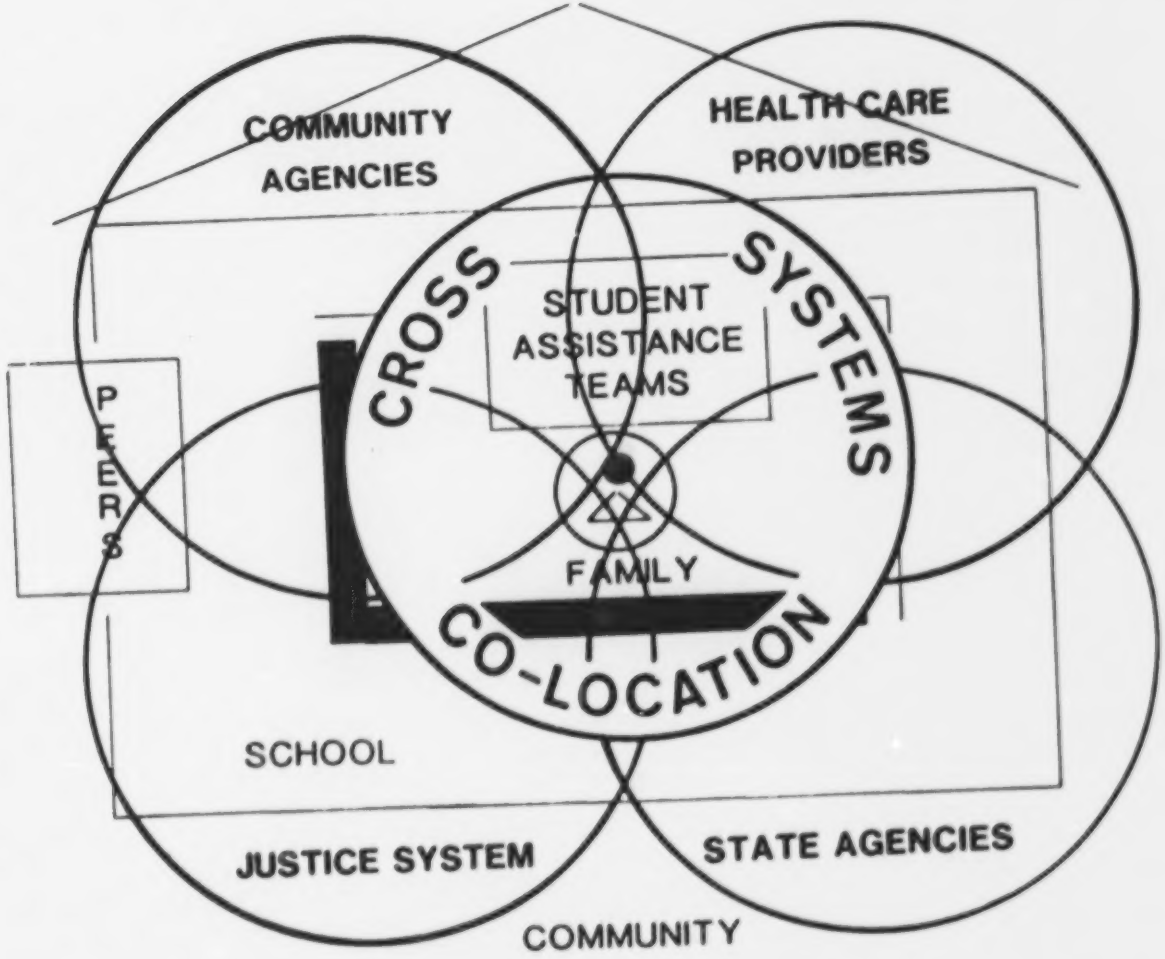
STATE AGENCIES
STUDENT ASSISTANCE TEAM
PEERS
SCHOOL
FAMILY
JUSTICE SYSTEM
COMMUNITY


COMMUNITY AGENCIES
HEALTH CARE PROVIDERS
CROSS SYSTEMS
STUDENT ASSISTANCE TEAMS
PEERS
FAMILY
CO-LOCATION
SCHOOL
JUSTICE SYSTEM
STATE AGENCIES
COMMUNITY

STRATEGIC INTERVENTION FOR HIGH RISK YOUTH (SIHRY)

KEY PARTNERS:

- Bridgeport Futures Initiative
- Regional Youth/Adult Substance Abuse Program
- Bridgeport Department of Police
- Bridgeport Public Schools
- Superior Court of Juvenile Matters
- Family Services Woodfield

FUNDERS:

- Center on Addiction and Substance Abuse at Columbia University
- The Annie E. Casey Foundation
- U.S. Bureau of Justice Assistance
- Office of Justice Programs

TARGET POPULATION: Eleven (11) to thirteen (13) year old adolescents at risk of involvement with drugs and drug related crime.

TARGET NEIGHBORHOOD: The East Side of Bridgeport is the target neighborhood for the SIHRY Project. The street boundaries include Crescent Avenue, Knowlton Avenue, Boston Avenue, and Helen Street.

TARGET SCHOOL: Luis Munoz Marin and Garfield Schools in the target neighborhood.

PROGRAM INTERVENTIONS:

♦ **PREVENTION/INTERVENTION**

- Afterschool and Summer Activities
- Case Management Services
- Peer Mediation Training

♦ **CRIMINAL/JUSTICE INTERVENTION**

- Police Officer Sector Terminal (POST)
- Phoenix Project
- East Side Community Council
- Community Policing and Problem Solving Training

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For more information, please call Carmen Siberon at: 576-4965.

STRATEGIC INTERVENTION FOR HIGH RISK YOUTH (SIHRY)

PREVENTION/INTERVENTION

Afterschool and Summer Activities

As a prevention strategy the following neighborhood agencies provide positive youth development activities for SIHRY program participants:

- A.B.C.D.
- Bridgeport Community Health Center
- Hall Neighborhood House
- Luis Munoz Marin School
- Orcutt Boys and Girls Club
- McGivney Community Center

STRATEGIC INTERVENTION FOR HIGH RISK YOUTH (SIHRY)

PREVENTION/INTERVENTION

Case Management Services

The following interagency Co-location Team is providing intensive case management intervention for SIHRY participants and their families:

- Bridgeport Health Department/Schoolbased Health Center
- Bridgeport Police Deapartment/Neighborhood Patrol Officer
- Child Guidance Center
- Family Services Woodfield*
- Juvenile Parole Officer
- State Department of Social Services (DHR & DIM)
- Luis Munoz Marin School Administrators/SIHRY Liaison/School Guidance Counselor and Social Worker

* Family Services Woodfield is under contract to provide 4.5 Family Mentors/Case Managers.

STRATEGIC INTERVENTION FOR HIGH RISK YOUTH (SIHRY)

PREVENTION/INTERVENTION

Peer Mediation Training

Peer mediation can provide an effective alternative to the discipline code and procedures used in a school. The training will establish a peer mediation program at Luis Munoz Marin School and involve the surrounding community including:

- School Staff
- Parents
- Police and Security Officers
- Service Providers
- Students

STRATEGIC INTERVENTION FOR HIGH RISK YOUTH (SIHRY)

CRIMINAL/JUSTICE INTERVENTIONS

Police Officer Sector Terminal (P.O.S.T.)

The P.O.S.T. is a donated storefront space on East Main Street, shared by police officers and SIHRY case management staff. Increase police presence in the target neighborhood and integration of law enforcement and social services introduces the concept of community policing and problem solving in addressing the issue of drugs and related crime in a community. Staff from the following agencies have their offices at the P.O.S.T.:

- Bridgeport Futures Initiative
- Bridgeport Police Department
- Family Services Woodfield
- Other agencies use P.O.S.T. to meet with SIHRY participants

STRATEGIC INTERVENTION FOR HIGH RISK YOUTH (SIHRY)

CRIMINAL/JUSTICE INTERVENTIONS

Project Phoenix

Project Phoenix is a neighborhood traffic diversion strategy to minimize easy access for illegal drug transaction in the target neighborhood. The following organizations participated in the installment of Jersey Barriers to change the traffic flow pattern on the East Side, and reduce drug trafficking:

- Bridgeport Police Department
- Bridgeport SIHRY East Side Community Council
- Connecticut Army National Guard
- Connecticut Air Force National Guard
- Connecticut State Police
- Connecticut State Department of Corrections

STRATEGIC INTERVENTION FOR HIGH RISK YOUTH (SIHRY)

CRIMINAL/JUSTICE INTERVENTIONS

East Side Community Council

The East Side Community Council evolved from the Neighborhood Public Safety Partnership initiated by SIHRY. The council developed into a coalition of existing East Side groups working on a variety of "quality of life" issues, including youth activities, affordable housing, public health, as well as public safety. The members represent the following groups of people:

- Local Merchants
- Service Providers
- Community Organizations
- Neighborhood Residents

STRATEGIC INTERVENTION FOR HIGH RISK YOUTH (SIHRY)

CRIMINAL/JUSTICE INTERVENTIONS

Community Policing Training

The goal of community policing is to empower communities, so that they can help make their neighborhoods better, safer, and healthier places in which to live and work. Community policing aims to build a new community-based partnership, and it provides a fresh approach to creative problem solving, which can be applied to crime, social and physical disorder, and overall quality of life. Training participants includes:

- Police Officers
- Social Service Providers
- Neighborhood Residents

STRATEGIC INTERVENTION FOR HIGH RISK YOUTH (SIHRY)

PREVENTION/INTERVENTION

Case Management Services

The following interagency Co-location Team is providing intensive case management intervention for SIHRY participants and their families:

- Bridgeport Health Department/Schoolbased Health Center
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- Child Guidance Center
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- Juvenile Parole Officer
- State Department of Social Services (DHR & DIM)
- Luis Munoz Marin School Administrators/SIHRY Liaison/School Guidance Counselor and Social Worker

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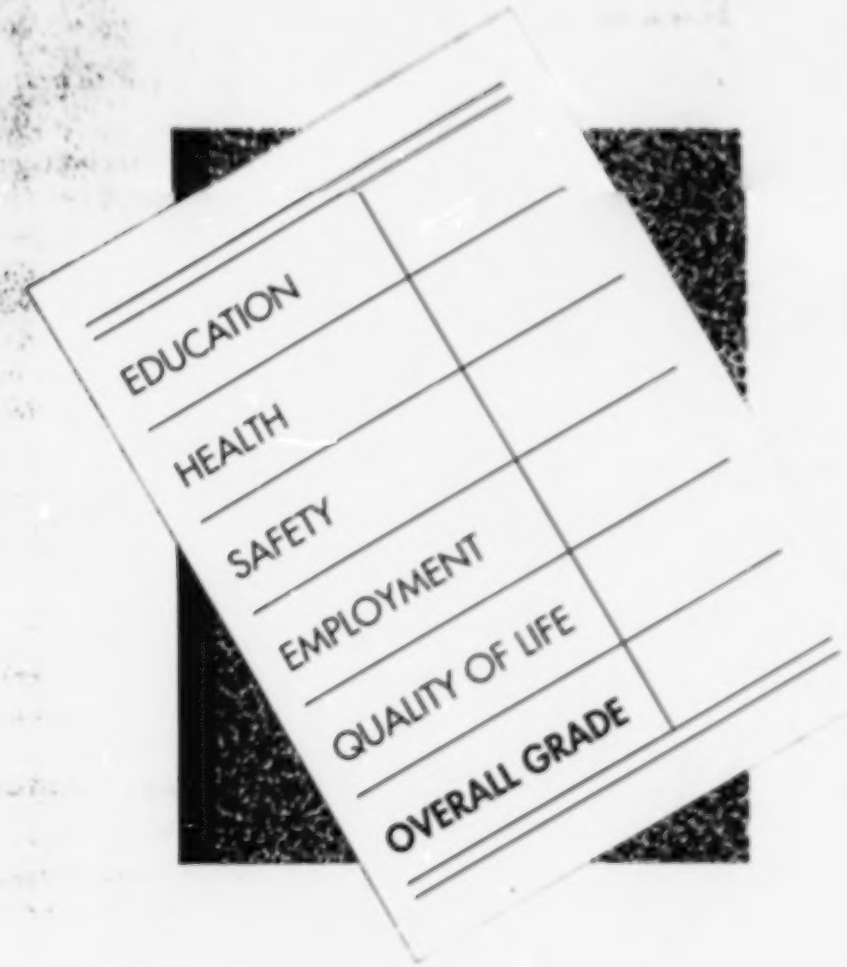

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ON THE STATE OF OUR CHILDREN

BRIDGEPORT FUTURES INITIATIVE
1993

PREFACE

The pages of this first annual *Bridgeport Report Card on the State of Our Children* present a statistical profile of the realities encountered by our children each and every day. This information is presented not to immobilize the adults responsible for the well-being of our children. Rather, it is intended to stimulate us, as a caring community, to take immediate action and respond to the needs of children.

If this document came with an instruction manual, it would caution the reader that the contents are dangerous if not used under the proper conditions. This report should be used as a tool for changing the condition of children's lives, not as a weapon by which to assign blame. This first report card will establish a baseline reading of the status of children for the purpose of measuring our progress as adults in affecting positive change over time.

A report card should reflect both strengths and weaknesses — positives and negatives. It should provide information on how strategies exist for further development. These efforts are intended to encourage people to continue their activities through collaborative systems.

This report, then, should be seen as a starting point or foundation for what is to come. To know where you are heading, it's necessary to know where you have been. The next phase of this report will address all issues — both the pros and cons — to provide a clearer indication of what has changed and how, and what needs to be worked on further.

Many thanks are extended to the individuals and organizations who contributed the time and information that made this report card possible. There are currently many efforts in Bridgeport with the mutual goal of improving the quality of life for children. It is hoped that this report is a rallying point for collaborative action and a tool for accountability and measuring the impact of our efforts on behalf of children.

This *Bridgeport Report Card* could not be produced without the help of numerous people to whom Bridgeport Futures Initiative offers much appreciation. A special "thank you" to Bridgeport Child Advocacy Coalition Research Consultant Barbara Edinberg for collecting and analyzing the data, and to past Executive Director Maria Mojica and past Oversight Collaborative Chairman Gus Serra for their input.

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Introduction

The pages that follow are a compilation of available information on the status of Bridgeport's children. As appropriate, this report also provides thoughtful analysis of the data by individuals and organizations who are experts in the field. Based on this information, the Bridgeport Futures Oversight Collaborative has set quantitative and qualitative goals for improving the quality of life for children. The Oversight Collaborative will assess on a yearly basis its progress toward its goals for children and issue a report to the community.

The first section of the report presents a demographic profile of children in Bridgeport and patterns of service utilization. This information stands as proxy measures of need in a community. The second section examines in detail information on four critical issues affecting the lives of children. Statistical and trend information is provided in the areas of substance abuse, teenage pregnancy/health, education, and youth employment.

The third section contains the goals as established by the Oversight Collaborative. It also outlines the process by which progress will be measured. The proposed methodology will assess the efficiency of a collaborative community-based process to positively impact quantitative measures of youth success.

Bridgeport Demographics and Service Utilization

The number of children five years of age and younger has increased significantly in Bridgeport over the past decade.

In 1990, there were 36,992 children in Bridgeport representing 26 percent of the population. While the total number of children has declined 7 percent since 1980, the number under three years of age has risen 5 percent, and from three to five years of age, nearly 6 percent. These combined age groups represent 14,013 children, or 38 percent of the total 36,992 children under 18 years old (U.S. Bureau of the Census [USBC], 1991, Table P11/12; USBC, 1981, Table 10). (See Table 1.)

Although the number of older children (6-13 and 14-17) decreased substantially (6.2 percent and 25.7 percent respectively), these numbers will increase within the decade as the "boomlet babies" (children now under the age of five) become adolescents.

TABLE 1:
Total number of Bridgeport children by age group and by percentage of total population, 1990.

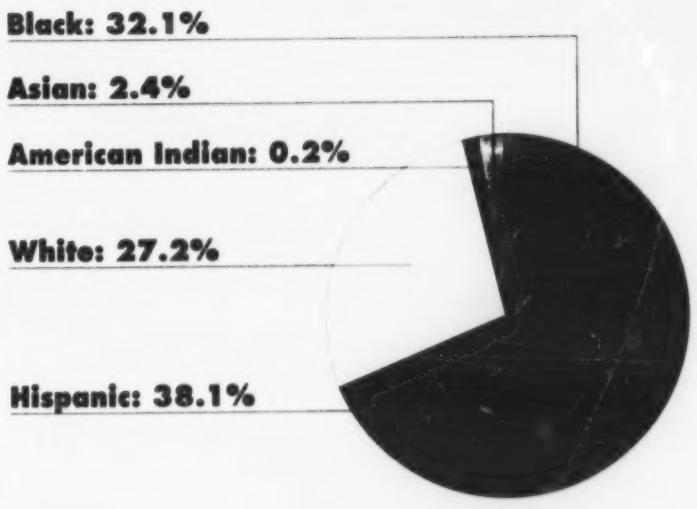
1990 Age Breakdown	Number	Percent change from 1980
Under 3	7,323	+5.0%
Age 3-5	6,690	+5.6%
Age 6-13	15,858	-6.2%
Age 14-17	7,121	-25.7%
Total Children	36,992	-7.1%
Total Bridgeport Population	141,686	-0.6%
Percent Children of Total Population	26.0%	28.0%

Source: U.S. Bureau of the Census. (1981). *Connecticut: 1980 Census of Population*. Table 10; and U.S. Bureau of the Census. (1991). *Connecticut 1990 Census, Complete Count Data*. (Summary Tape File 1A). Table P11/12.

During the last decade, there has been an increase in the proportion of Bridgeport children of color compared to white children. An increase is seen in the proportion of black, Hispanic and Asian children.

Nearly 75 percent of all children in Bridgeport are non-white. In 1990, 32.1 percent of Bridgeport children were black, 38.1 percent were Hispanic, 2.4 percent were Asian and 0.2 percent were American Indian. White children constituted 27.2 percent of the child population, a decrease of 10 percent since the 1980 Census (USBC, n.d., Special Computer Run; USBC, 1981, Table 12/13). (See Figure 1.)

FIGURE 1:
Racial composition of Bridgeport children under the age of 18 by percentage, 1990.



Source: U.S. Bureau of the Census. (n.d., Special Computer Run). *1990 Census of Population and Housing: Modified Age/Race/Sex File, Data for Bridgeport, Connecticut.*

Nearly 40 percent of Bridgeport children live in single-parent households.

Children in single-parent households, especially those headed by women, are at greater risk of dropping out of school, substance abuse, adolescent pregnancy, juvenile delinquency, mental illness and suicide (National Commission on Children [NCC], 1991, p. 253).

Of the 36,992 children under 18 years old, at least* 39.4 percent are being raised in single-parent households (USBC, 1991, Table P21). That is, at least* 14,569 children under the age 18 live in single-parent households (USBC, 1991, Table P21).

Of children in single-parent families, 89 percent of those under 18 (12,926) live in households headed by single mothers (USBC, 1991, Table P21).

*This number does not include other children living in the household who are not a part of the immediate family or those children living in institutions.

TABLE 2:
Languages other than English spoken by Bridgeport Public School students in order of frequency.

Spanish	Urdu
Portuguese	Hindi
Vietnamese	Pushto
Laotian	Turkish
Khmer (Camb)	Armenian
Haitian/Creole	Syriac
Chinese	Thai
French	Greek
Bengali/Bengla	Ganda
Polish	Gujarati
Cape Verde/Creole	Hausa
Albanian	Hungarian
Italian	Lithuanian
Romanian	Slovak
Arabic	Ukrainian

Source: Bilingual Education Services, Bridgeport Public Schools. (1993).

Bridgeport is a bilingual community.

The Census estimates that nearly 7 percent or 9,844 Bridgeport residents speak English "not well" or "not at all." Twenty percent or 28,293 speak Spanish "in addition to another language" in their homes. Also, 18,765 respondents speak Asian (Pacific Island) or another language in addition to English. About 60 percent of all respondents speak only English (USBC, 1992b, Table P28). This lingual diversity is represented in the Bridgeport Public Schools. (See Table 2.)

Change of residence is common in the Bridgeport community.

According to a Census sample, between 1985 and 1990 nearly half of those Bridgeport residents counted by the Census moved from one household to another either in the U.S. or Puerto Rico. Of these, 73.1 percent moved within Fairfield County, 12.3 percent moved to a different state and 11.3 percent moved abroad (USBC, 1992b, Table P43/44).

TABLE 3:
Educational attainment of Bridgeport persons 18 years of age and older by number and percentage, 1990.

Level of Schooling	Persons 18+	Percentage
Elementary	16,859	16.1%
Some High School (no diploma)	22,615	21.6
High School	32,867	31.4
Some College	15,661	15.0
Associate's Degree	4,499	4.3
Bachelor's Degree	7,995	7.6
Graduate/ Professional Degree	4,202	4.0
Total	104,698	

Source: U.S. Bureau of the Census. (1992b). *Connecticut Census Sample Data.* (Summary Tape File 3A). Table P57/58/59/60.

Over one-third of Bridgeport residents have not completed high school.

A 1990 Census sample estimates that about 16 percent of Bridgeport residents have only completed elementary school and 22 percent have not received a high school diploma (USBC, 1992b, Table P57/58/59/60). (See Table 3.) Limited education is one of the surest predictors of poverty.

More Hispanic respondents than any other race do not complete high school. Fifty-eight percent of Hispanic respondents of all races* did not complete high school, compared to 37 percent of blacks, 37 percent of whites, 40 percent of American Indians and 39 percent of Asians (and Pacific Islanders) (USBC, 1992b, Table P57/58/59/60).

*Hispanics are counted twice in the 1990 Census. One Census question asks respondents to designate race (i.e., "White," "Black," "American Indian," "Asian," or "Other"); a follow-up question asks, "Are you of Hispanic origin?" In all the following references to "Hispanics" in this report, the respondents can be of Hispanic origin of any race.

Twenty-nine percent of Bridgeport children come from poor households.

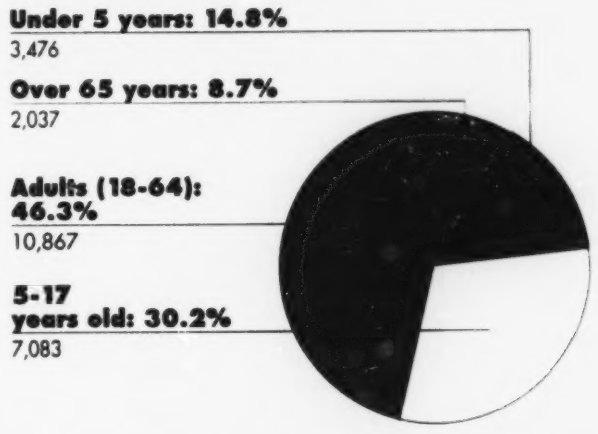
In 1990, a family of four had to earn $12,674 or less to be considered in poverty (USBC, 1992a, p. B-27). Based on these numbers, the Census estimates that:

- 17 percent of Bridgeport residents were defined as poor (USBC, 1992b, Table P117/119/120).
- 29 percent (10,559) of all children under the age of 18 were living in poverty (USBC, 1992b, Table P117/119/120).
- While children represented 26 percent of the total Bridgeport population, they constituted 45 percent of the population in poverty (USBC, 1992b, Table P117/119/120). (See Figure 2.)

Risk of poverty increases substantially for single-parent households, particularly those that are female-headed. About 84 percent of all children living in poverty are from single-parent households, compared to approximately 16 percent living with both parents (USBC, 1992b, Table P126). (See Figure 3.)

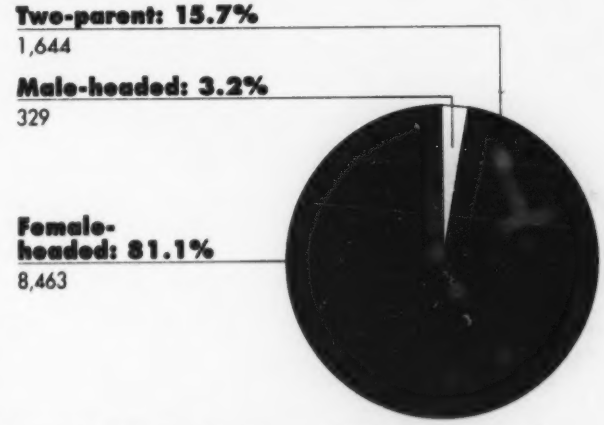
It is well recognized that poor children are more likely not to attend preschool, get in trouble in school, have weak basic academic skills and adolescent pregnancies; also, they experience more hunger, homelessness and violence. They are also two times as likely to be retained a grade than someone who is not poor. Poverty also places children at heightened risk of health and nutritional problems (Children's Defense Fund [CDF], 1991, p. 21).

FIGURE 2:
Percentage of Bridgeport poor adults and children by age group, 1990.



Source: U.S. Bureau of the Census. (1992b). Connecticut Census Sample Data. (Summary Tape File 3A). Table P117/119/120.

FIGURE 3:
Percentage of poor children from two-parent, male-headed, and female-headed households, 1990.



Source: U.S. Bureau of the Census. (1992b). *Connecticut Census Sample Data.* (Summary Tape File 3A). Table P126.

Bridgeport children of color are more likely to be poor.

Proportionally, there are greater numbers of children of color who are poor. (See Table 4.) Twenty-five percent of white children; 44 percent of Hispanic children of all races; 30 percent of black children; 54 percent of American Indian children and 12 percent of Asian children are poor (USBC, n.d., Special Computer Run, Table P119/120).

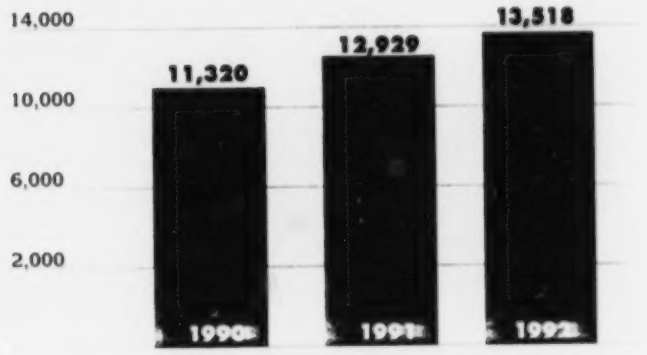
TABLE 4:
Poverty status of race and Hispanic origin for children under the age of 18.*

	Total <18	Below Poverty
White	16,552	4,054
Black	12,212	3,653
American Indian	87	47
Asian	860	99
Other	6,515	2,706
Total	**36,226**	**10,559**
Hispanics of all Races	13,453	5,913

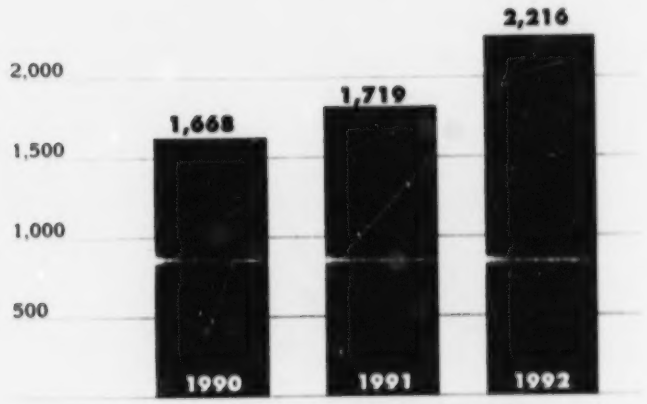
*Persons for whom poverty status is determined.

Source: U.S. Bureau of the Census. (n.d., Special Computer Run). *1990 Census of Population and Housing.* (Summary Tape File 3). Table P119/120.

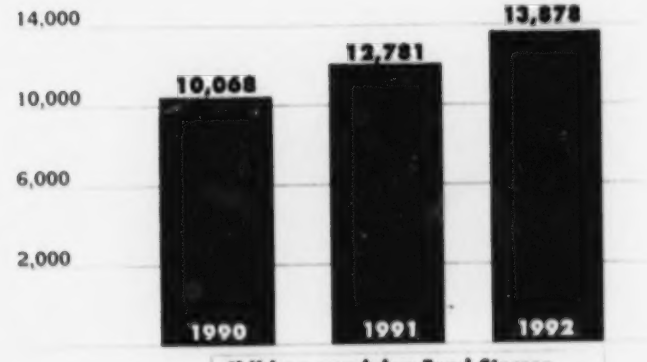
FIGURE 4:
Number of Bridgeport children receiving public assistance, June 1990-1992.



Children receiving AFDC



Children receiving Medicaid



Children receiving Food Stamps

Source: Connecticut Department of Social Services.* (1990; 1991; 1992). *Eligible Recipients by Age for June.*

There has been a steady increase in the number of children receiving public assistance.

From 1990 to 1992, the number of children receiving AFDC (Aid to Families with Dependent Children) benefits, Medicaid and Food Stamps has continued to increase. Comparing June 1990 to June 1992, there was an increase of 28 percent in youth recipients (Connecticut Department of Social Services* [DSS], 1990, 1991, 1992). (See Figure 4.)

*Formerly, Department of Income Maintenance.

HEALTH

Good health is essential to a child's growth and development.

There are several indicators of a community's health including infant mortality (deaths up to one-year of age) and low birthweight (under 5.5 pounds). These can signal that other health and socio-economic problems also exist. Babies born at low birthweight are more likely to die before their first birthday or have developmental problems (CDF, p.61). Low-birthweight babies are also more prone to learning disabilities and behavioral problems. In many cases, they also are at higher risk of social problems such as child abuse.

In 1989, almost 15 babies died for every 1,000 live births and about 10.5 percent of total Bridgeport babies born were underweight (Connecticut Department of Public Health and Addiction Services* [DPHAS], 1991a; 1991b). (See Table 5.)

Black babies** are at greater risk of infant mortality and low birthweight. According to 1989 figures, infant mortality for black babies was 17.1/1,000 live births. Nearly 14 percent of black babies were born underweight (DPHAS, 1991a).

TABLE 5:
Infant mortality and low birthweight of total population and blacks, 1985-1989.
(Because these are small numbers, it must be noted that a minor increase in the number of deaths can substantially affect the overall rate.)

Infant Mortality/1,000

	1985	1986	1987	1988	1989
Total/1,000	15.0/1,000	8.9/1,000	14.1/1,000	10.0/1,000	14.7/1,000
Blacks	21.6/1,000	13.6/1,000	22.8/1,000	13.8/1,000	17.1/1,000

Low Birthweight (<2,500 grams) by Percentage

	1985	1986	1987	1988	1989
Total %	9.5%	8.1%	11.2%	9.1%	10.46%
Blacks	13.5%	11.5%	14.5%	13.5%	13.97%

Source: Connecticut Department of Public Health and Addiction Services.* (1991a; 1991b).

* Formerly, Department of Health Services.

**Statistics are only available for infant mortality and low birthweight for all of Bridgeport and the black population. There are no separate figures for Hispanic women and children.

Prenatal care is another major indicator of community health.

Mothers who don't receive prenatal care are at risk of having premature delivery and children of low birthweight. In 1991, provisional data from the Connecticut Department of Public Health and Addiction Services indicate that 83 percent of Bridgeport women received adequate prenatal care (receiving prenatal care during the first trimester), an increase of 12 percent from 1990 (DPHAS, 1991a; 1992c). (See Table 6.)

Adolescents have a tendency not to seek prenatal care: this raises the risk of premature birth and low birthweight. In 1988, low birthweight among adolescents was 12.2 percent (DPHAS, 1991a; 1991b). (See Table 7.) (Also see additional information in section from Greater Bridgeport Adolescent Pregnancy Program Report on page 28.)

TABLE 6:
Percentage of mothers with late (after first trimester) or no prenatal care, 1984-1991.
(Only records included where information is known.)

	1984	1985	1986	1987	1988	1989	1990	1991*
Total %	24.4%	23.8%	23.8%	22.8%	28.8%	30.4%	29.0%	17.0%

*Provisional data.

Source: Connecticut Department of Public Health and Addiction Services. (1991a; 1992c).

TABLE 7:
Percentage of low birthweight among teens, 1984-1988.

	1984	1985	1986	1987	1988
Total %	11.8%	13.0%	9.9%	14.0%	12.2%

Source: Connecticut Department of Public Health and Addiction Services. (1991a; 1991b).

The health of Bridgeport's children falls significantly short of the goals set to improve the status of American children by the year 2000.

In 1990, the U.S. Public Health Service, the Surgeon General, President George Bush and the National Governors' Association, among others, established goals to improve the status of American children by the year 2000. In prenatal care, low birthweight, infant mortality, and the number of adolescent pregnancies, Bridgeport is considerably below these goals (CDF, pp.16-18). (See Table 8.)

TABLE 8: Comparison of U.S. versus Bridgeport as per established goals for improved status of children.

Prenatal Care	
U.S. Goal	**Bridgeport**
Increase to 90 percent the proportion of women who receive prenatal care in the first three months of pregnancy. (This reflects 10 percent receiving late or no prenatal care.)	In 1991, 83 percent of women received adequate prenatal care. (This figure is based on the birth records in which all information is completed on prenatal care by attending physician.)
Infant Mortality	
U.S. Goal	**Bridgeport**
Reduce the rate of infant mortality to no more than 7/1,000 live births overall and no more than 11/1,000 births for black babies.	In 1989, the total infant mortality rate was 14.7 infant deaths/1,000 live births. It was 17.1/1,000 for blacks.
Low Birthweight	
U.S. Goal	**Bridgeport**
Reduce to no more than 5 percent the proportion of babies born of low birthweight.	In 1989, 10.46 percent of all babies were low in birthweight and 13.97 of black babies.
Teen Pregnancy	
U.S. Goal	**Bridgeport**
Reduce pregnancies among girls 17 and younger to no more than 50/1,000 live births. Reduce the pregnancy rate among black girls in this age group to no more than 120/1,000 live births.	In 1989, of the total number of births by girls under the age of 20, 177/1,000 live births were to all teens and 233/1,000 live births to black teens.

Source: Children's Defense Fund. (1991). pp. 16-18.

Babies prenatally exposed to drugs are more likely to suffer from a greater range of medical problems than non-exposed babies.

In Bridgeport, as in the rest of the U.S., there is a growing number of children born to mothers who use drugs or alcohol during pregnancy. It is estimated that as many as 500 babies in Bridgeport are born each year prenatally exposed to drugs (Bridgeport Child Advocacy Coalition [BCAC], 1992).

Problems associated with substance abuse during pregnancy may include prematurity, infant mortality and intrauterine growth retardation with smaller head circumference. Babies born to substance-abusing women have a 50 percent higher risk of abuse and neglect than infants born to mothers who do not abuse drugs.

In 1991, an anonymous drug and alcohol screening survey was conducted over a five-week period on all women delivering babies at the then three Bridgeport hospitals. Of the 390 patients screened:

- 13 percent showed levels of alcohol.
- 18 percent showed some level of drugs including cocaine, opiates, marijuana or amphetamines.
- Mothers showing drug or alcohol levels had fewer prenatal visits and poorer birth outcomes than non-users.
- Drug usage crossed socio-economic lines; 39 percent of all maternal drug users were private patients.
- Of the 78 teenage mothers in the study, 15 percent showed levels of alcohol, but there was no significant drug use (deRegt, 1991).

Bridgeport constitutes 10 percent of the pediatric AIDS cases in Connecticut. Nationwide, AIDS cases are increasing at a faster rate among women and newborns than any other age group (Klerman, 1991).

From 1981 to 1992, there were eight cases of pediatric AIDS in Bridgeport children. Of these, four have since died. The majority of these cases resulted from mothers who were IV drug users or had sexual relations with IV drug users who were HIV positive (DPHAS, 1992b).

The incidence of syphilis has declined dramatically, but other sexually transmitted diseases remain high among youth.

Reported cases of syphilis among youth 19 and under have declined significantly in the last three years from 23 cases in 1989, to 22 in 1990 and three in 1991 (Kiely, 1992). (See Table 9.)

In 1991 for youth 19 and under, there were 295 reported cases of gonorrhea and 381 cases of chlamydia (DPHAS, n.d., *Yearly Report*). Chlamydia, if untreated, can lead to pelvic inflammatory disease and infertility.

TABLE 9:
Number of Bridgeport youths 19 years of age and younger with sexually transmitted diseases, 1988-1991.

	1988	1989	1990	1991
Syphilis	10	23	22	3
Gonorrhea	325	289	284	295
Chlamydia	NA*	NA	142	381

* Reports of chlamydia to the Connecticut Department of Public Health and Addiction Services began in 1990.

Source: Connecticut Department of Public Health and Addiction Services. (n.d.) *Yearly Report*.

Children are suffering from diseases that are preventable through immunizations.

Due to a number of possible factors including poor nutrition, inconsistent medical care and substandard housing, poor children are more vulnerable to a number of health-related problems. These may include irreparable neurological damage in severe cases of measles and whooping cough, hearing problems from ear infections, and slow development and learning problems from anemia. These conditions can be prevented with proper medical care and/or age-appropriate immunizations (NCC, p.31).

In Bridgeport, although children must be immunized when they enter kindergarten, it is estimated that as many as 50 percent of Bridgeport's children are not being immunized earlier in their lives, as recommended in the "National Standards of Pediatric Immunization Practice" (Huettner, 1992).

The reported cases of measles, pertussis, mumps and diphtheria are relatively low, but instances of hepatitis B, a contagious disease, are high. There were 20 reported cases of youth under the age of 18 having this disease in 1991 (Kiely, 1992).

Tuberculosis is becoming a serious public health concern. While there were three active cases of TB in 1991, during this same time period there were 200 children infected with tuberculosis that could become active without preventive therapy. These children are being monitored by the Bridgeport Health Department (Kiely, 1992).

Lead poisoning continues to be a serious medical problem for Bridgeport children.

More than 80 percent of Bridgeport's children under the age of six years are at risk of lead poisoning. The Bridgeport Health Department Lead Prevention Program estimates that 98 percent of Bridgeport's dwelling units were built before 1950 and have lead-based paint.

In 1992, 1,424 children under the age of six were tested for lead. Of these children, 380 tested positive (Gaines, 1993).

Lead poisoning is one of the most common childhood conditions and most prevalent environmental health hazard in the U.S. Even low levels of lead can cause deterioration of the central nervous system, developmental delays, hearing problems, impaired blood production, growth defects and poor motor coordination (CDF, p.66).

Homicide is the leading cause of death in Bridgeport adolescents, followed by suicide.

In 1988, the leading cause of death of all children (0-19 years of age) was complications from certain conditions originating in the perinatal period (DPHAS, n.d., *Causes of Death*, Table 17).

During this same year, the leading cause of death of adolescents (10-19 years of age) was homicide (10) followed by suicide (4).

Adolescents are especially vulnerable to behavior which places them in jeopardy of personal health and safety (DPHAS, n.d., *Causes of Death*, Table 17).

Poor nutrition significantly increases the risk of low birthweight, infant mortality and life-long disability.

Pregnant women and children need adequate food for proper growth and development. Children with inadequate diets may lag in growth, have more and longer-lasting infectious diseases and difficulties with cognitive development. Hungry children have a shortened attention span and reduced short-term memory (NCC, p.124; CDF, p.65). They suffer twice as many health problems and are absent three times as many school days as non-hungry children (BCAC, 1991).

TABLE 10:
Total number of women and children recipients of the Special Supplemental Food Program for Women, Infants and Children (WIC), 1989-1992.

	1989	1990	1991	1992
Women	1,130	1,081	1,033	851
Infants (<1 yr.)	1,503	1,671	1,593	1,677
Children	4,032	4,468	4,479	4,649
Total Children	5,535	6,139	6,072	6,326
Grand Total Women and Children	6,665	7,220	7,105	7,177

Source: Epstein, Bridgeport WIC Program. (1992).

In June 1992, 6,326 infants and children received benefits from the Supplemental Food Program for Women, Infants and Children (WIC), in addition to other assistance programs. (See Table 10.) This is an increase of 14 percent over the last four years. This number does not account for all families in need; estimates are that WIC serves just over 75 percent of those eligible (Epstein, 1992).

In June 1992, nearly 14,000 children received assistance through food stamps (DSS, 1990, 1991, 1992). However, food assistance programs are often not sufficient to meet the needs of families. On the average, food stamps will cover the costs of a family's food for less than one month.

In the 1992-93 school year, 71 percent of all public school students were eligible for free or reduced-price lunches (Huydic, 1992). In 1992, the Bridgeport School System also began to offer school breakfasts. Approximately 40-45 percent of children in the school lunch program participate in school breakfasts (Araya, 1992).

An estimated 15 percent of Bridgeport's children suffer from some degree of mental health problem.

Childhood psychiatric and behavioral disorders are often severe and may lead to life-long impairments in social functioning, adaptation and productivity (NCC, p. 34).

Some mental health problems are biological, others are due to chronic maltreatment and compounded by the stresses of poverty. In general, poor children do not receive proper mental health care. Violence also contributes to emotional disturbances (CDF, p. 122).

In 1988, there were four suicides among adolescents, however the number of suicide attempts is believed to be much higher (DPHAS, n.d., Causes of Death, Table 17).

The U.S. Public Health Service estimates that nationally 12 percent of children under 18 suffer from a mental health problem. Three percent have a serious emotional disturbance and 1 percent have a most serious emotional disturbance.*

Based on these estimates and using the 1990 Census figures, it is estimated that in Bridgeport:

- 4,439 children (0-17 years of age) have mental health problems,
- 1,109 have a serious emotional disturbance, and
- 370 have a most serious emotional disturbance (Connecticut Department of Children and Families [DCF],** 1992, p. 4).

*Literature on children's mental health acknowledges the absence of universally accepted definitions of "chronic mental illness," "serious emotional disturbance" or "serious emotional maladjustment." To be considered eligible for mental health services for the Connecticut Department of Children and Families, children and youth must be diagnosed by a mental health professional as having emotional and/or organic impairment manifested by emotional or behavioral symptoms resulting in substantial functional limits in two or more major life activities, and have a defined mental health problem diagnosable under DSM-111-R (DCF, 1992, p. 4).

**Formerly, Department of Children and Youth Services.

VIOLENCE

The number of Bridgeport juveniles in out-of-home placements for delinquency has remained constant.

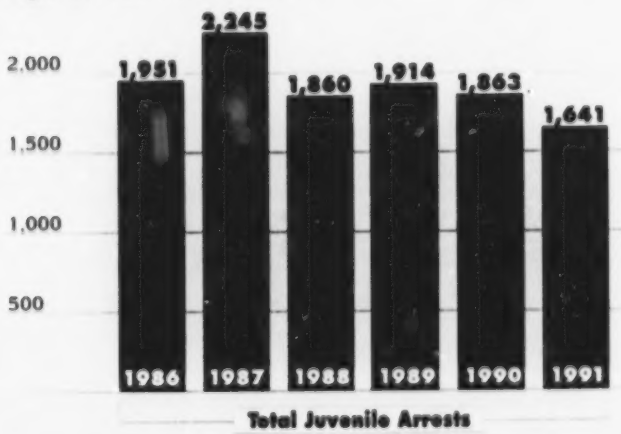
Seventy-five children were deemed delinquents and removed from their parents' homes in State Fiscal Year 1991-92.

This number is consistent with earlier years (DCF, *The Town Page, 1992*).

The proportion of arrests in Bridgeport for violent crimes by adolescents has remained steady since 1988.

There was a decrease in the number of juvenile arrests for all crimes from 1,863 in 1990 to 1,641 in 1991 (Connecticut Department of Public Safety [DPS], 1991; 1992a). (See Figure 5.) This does not include the arrests of juveniles committing crimes in other surrounding communities. This decrease could be attributable to 1) a decline in the number of police officers due to budget cutbacks and/or 2) a change in law enforcement efforts such as a selective emphasis on "gateway" crimes (e.g., there were 364 arrests for auto theft) and finding alternatives to arrests in incidences of low-grade crimes (e.g. disorderly conduct, simple assaults, vandalism) (Sweeney, 1992).

FIGURE 5:
Number of total arrests of juveniles under the age of 18, 1986-1991.



Source: Connecticut Department of Public Safety. (1992a).

The proportion of juveniles arrested for violent crimes (murder, forcible rape, robbery and aggravated assault) has remained steady since 1988, with 115 in 1991 (DPS, 1989; 1990; 1991; 1992a).

Youth homicides are significant. Twelve homicide victims or one out of five (those killed in Bridgeport, but not necessarily residents of the city) in 1991 were under the age of 20 (DPS, 1992b).

FAMILY SUPPORT

Children's most basic needs are met by their families.

Children cannot be looked at in isolation, but rather in relationship to their families which greatly impact their lives. A child needs a strong, stable family and enduring, supportive relationships to properly grow and develop (NCC, p.281).

Several factors can contribute to the parent(s)' inability to provide this supportive environment and may even lead to child abuse or neglect: single-parenthood, poverty, homelessness, adolescent pregnancy and drug abuse (NCC, p.284).

During State Fiscal Year 1991-92, 1,175 referrals were made to the Connecticut Department of Children and Families for child protection for Bridgeport children under the age of 18. About 550 of

TABLE 11:
Total number of admissions to the Connecticut Department of Children and Families and the results of these referrals, State Fiscal Years 1987-1991.

	FY 1986-1987	FY 1987-1988	FY 1988-1989	FY 1989-1990	FY 1990-1991	FY 1991-1992
Total Referrals	986	1,233	1,112	1,014	1,105	1,175
Declared Victims of Abuse/Neglect through Court Decisions	125	141	166	172	174	120
Placed in Foster Care	191	271	211	194	180	125
Placed in Other Out-of-Home Placement	322	477	408	307	319	422

Source: Connecticut Department of Children and Families. (1986-1992). *The Town Page, Summary Information, State Fiscal Years 1986-92.*

these cases resulted in out-of-home placements. Although there was a steady decline from fiscal year 1987-88 to 1990-91, reflecting DCF's policy to keep families intact whenever possible, in State Fiscal Year 1991-92, there were 48 more children referred to out-of-home placements. There was also a decrease in referrals to foster family homes and private emergency shelters, but a significant increase to relatives' homes, other out-of-home placements, Long Lane School and group homes (DCF, 1986-1992, *The Town Page*). (See Tables 11 and 12.)

TABLE 12:
Out-of-home placement activity of Bridgeport children by the Connecticut Department of Children and Families, State Fiscal Years 1987-1991.

	FY 1986-1987	FY 1987-1988	FY 1988-1989	FY 1989-1990	FY 1990-1991	FY 1991-1992
Total	513	748	619	501	499	547
DCF Treatment Facilities	56	49	33	26	40	33
Other Residential Facilities	53	62	59	49	52	53
Foster Family Homes	191	271	211	194	180	125
Relatives' Homes (non-parents)	57	69	50	40	28	42
Other Out-of-Home	0	82	77	51	58	98
Long Lane School	39	62	62	56	56	109
Group Homes	49	49	37	20	17	32
Private Emergency Shelters	55	70	83	60	63	48
Independent Living	13	7	7	5	5	7

Source: Department of Children and Families. (1986-1992). *The Town Page, Summary Information, State Fiscal Years 1986-92.*

The number of working mothers has consistently grown. Of the 18,039 women with children under 18 years of age, 66 percent are in the labor force (USBC, 1992b, Table P73). (See Figure 6.)

Over 11,800 working women have children under the age of 18. The older the children, the more likely the mother is to be working:

- 58 percent of the women working have children under age six.
- 73.7 percent have children who are 6-17 years of age.
- 59 percent have children both under six and 6-17 (USBC, 1992b, Table P73).

Because of the high numbers of working mothers in the labor force, many children (especially those under six) receive care from child care providers other than their mothers. There is an acute need for infant, toddler and before- and after-school care (Dubow, 1992).

The child care that these children receive, especially those at the pre-school age, is an important factor in their future lives. Nurturing and stimulation in the children's earliest years is vital to their mental and physical well-being.

FIGURE 6:
Percentage of women with children under the age of 18 in the labor force, 1990.

Source: U.S. Bureau of the Census. (1992b). *Connecticut Census Sample Data.* (Summary Tape File 3A). Table P73.

It is estimated that about 61 percent (21,286) of all Bridgeport children under the age of 18 live in households where either both parents or the single parent are in the labor force (USBC, 1992b, Table P74).

Of all Bridgeport children under the age of 18:

- 11,979 live in households where both parents are in the work force;
- 9,307 live in single-parent households where the parent is in the labor force (USBC, 1992b, Table P74).

In Federal Fiscal Year 1991-92, almost one out of two people in Bridgeport homeless shelters were children.

Women and children comprise a growing proportion of the homeless population in Bridgeport. Of the 1,516 individuals staying at Bridgeport shelters, 746 were children during Federal Fiscal Year 1991-92 (October 1, 1991 through September 30, 1992) (Branch, 1992). (See Table 13).

TABLE 13:
Number of homeless in Bridgeport, Federal Fiscal Year, 1991-1992.*

Single Adults	532
Children**	746
Battered Women and their Children	168
Runaway Youth	140

* Federal Fiscal Year – October 1, 1991- September 30, 1992.
** Includes runaway youth in shelters and children of battered women in shelters.

Source: Branch, United Way of Eastern Fairfield County. (1992).

While the number of children in homeless shelters in Bridgeport decreased considerably from 769 in Federal Fiscal Year 1989-90 to 644 in 1990-91, it increased again to 746 in 1991-92. During this same period, there was also an increase in the number of battered women and their children at the shelters (124 in 1989-90, 130 in 1990-91 to 168 in 1991-92). One hundred forty children were runaway youths in Federal Fiscal Year 1991-92. However, shelter population alone is not an accurate indicator of homelessness. Fluctuations in shelter population from year to year is as much a reflection of length of stay, as numbers seeking housing. During Federal Fiscal Year 1991-92, 948 individuals were turned away from shelters because of the lack of available beds (Branch, 1992; United Way, 1991).

Results of the Regional Youth/Adult Substance Abuse Project's (RYASAP) 1992 Student Survey

The Regional Youth/Adult Substance Abuse Project (RYASAP) conducted a survey of students in the early spring of 1992 in the greater Bridgeport schools to determine the use of alcohol and drugs.

The survey was administered by the University of Connecticut Alcohol Research Center to 4,846 students from among fifth through twelfth graders enrolled in public and parochial schools in Bridgeport, Easton, Fairfield, Monroe, Redding, Stratford and Trumbull.

The new data update information from surveys randomly conducted with seventh- through twelfth-grade students in 1984 and in 1989, and for the first time measures the prevalence of drug and alcohol use by fifth and sixth graders. Forty-six public and parochial schools participated in the survey, and the resulting sample comprised 3,683 students in grades seven to twelve, and 1,163 students in grades five and six.

According to the findings, while the frequency of alcohol use by older students appears to be decreasing, fifth and sixth graders in substantial numbers are experimenting with drugs and alcohol.

The 1992 data show a continuing decline from 1989 in cocaine use with one-third as many seventh- through twelfth-grade students reporting use in the 30 days prior to the survey. However, cigarette and marijuana use has remained consistent, while regular use of alcohol has shown little change since 1984. The illicit use of prescription drugs has increased with 11 percent of students reporting abuse of downers, uppers or pain medications.

The most significant positive change over the past three years has been in the pattern of alcohol use among secondary school students. There is an encouraging decrease in the frequency of alcohol use compared to 1989. For example, the proportion of students who consume four or more drinks per occasion is one-half of what it was in 1989. The frequency of intoxication has also decreased.

Wherein one in five students reported getting drunk every weekend in 1989, only one in ten students did in the current survey. While the lifetime prevalence rate of alcohol use is still high, the results indicate that many students are beginning to modify their behavior in the use of alcohol, and the fact that 85 percent of the students report that they perceive regular alcohol use to be

harmful seems to confirm this significant trend.

The news is less optimistic about younger students, with the findings indicating that the onset of drug and alcohol experimentation is beginning at an earlier age—often at ten or 11 years. In the recent survey, 37 percent of the fifth- and sixth-grade students report having used cigarettes or smokeless tobacco, and 12 percent have illicitly used inhalants or pills.

The survey also indicated a marked diversity in the consumption of substances by suburban and urban students. While the use of marijuana by 13 percent of seventh- through twelfth-grade suburban and urban students is comparable, usage of cigarettes, alcohol and prescription drugs by students from the suburban communities is consistently higher than Bridgeport students. Twenty-six percent of suburban students contrasted to 23 percent of urban students reported using cigarettes in the 30-day period; 46 percent of suburban students had used alcohol one or more times versus 37 percent of urban students; and suburban students more regularly use illegal prescription drugs.

Providing an interesting contrast, experimentation with tobacco and alcohol by fifth and sixth graders is higher in Bridgeport than in the suburbs. This is the first survey of fifth and sixth graders, and therefore further surveys should reflect the causal variables defining these differences.

Through the auspices of the Robert Wood Johnson Foundation, RYASAP is able to continue to track prevalence trends among the region's students. Although much of the data is encouraging, it is apparent that there is a need to intensify efforts targeted to youth in the schools and communities, and to more effectively get the message of prevention out to younger students in the elementary grades.

Based on other reports, the task is more than stemming the tide of drug and alcohol abuse. In the greater Bridgeport region, there is an increase in gang activity, the availability and use of weapons, domestic abuse and violence. Any comprehensive effort needs to not only focus on substance abuse but to also address the whole spectrum of social problems.

Report By The Greater Bridgeport Adolescent Pregnancy Program, Inc. (GBAPP)

In the fall of 1990, The Greater Bridgeport Adolescent Pregnancy Program (GBAPP) convened a task force to examine problems related to teen pregnancy and early parenthood in greater Bridgeport, and to develop a strategic collaborative plan for addressing these issues.

Over 30 local agencies and institutions participated in the joint planning session. Subcommittees were established to focus on a variety of issues, including medical/health concerns (particularly the incidence of substance abuse during pregnancy), education and employment, social and support services for teens and policy recommendations.

Background

In 1988, more than 1,400 teens in greater Bridgeport became pregnant. Slightly less than half (43 percent) of these pregnancies resulted in births. The majority (84 percent) of these women remained single, a 50 percent increase from 1970.

Teenagers in Bridgeport under 20 had 533 babies in 1988, compared to 571 in 1970, a 7.1 percent decline between 1970 and 1988. In 1989, 545 babies were born to Bridgeport teens, a 2.3 percent increase from 1988. About 60 percent of all births to teens were non-white.

The number of Bridgeport teen births is almost double those of Connecticut (17.75 percent vs. 8.53 percent).

The proportion of teenagers in greater Bridgeport who are sexually experienced, as reported in 1990, range from 35 percent in middle school to 80 percent in high school. Rates of sexual activity for school dropouts are significantly higher.

Across all adolescent programs surveyed in greater Bridgeport in 1991, women under 20 are reported to have first become sexually active at an average of 14 years old; the age for males was lower, averaging 12 years. Estimates of the percentages of pregnancies which were intentional

Table 14
Number of adolescent births versus total births in Bridgeport, 1984-1991.

	Adolescent Births	Percent of Total Births
1984	559	20.4%
1985	539	19.7%
1986	528	18.8%
1987	523	18.4%
1988	533	18.3%
1989	545	17.75%
1990	544	17.7%*
1991	532	18.1%*

*Provisional data.

Source: Connecticut Department of Public Health and Addiction Services. (1991a; 1992c).

ranged from 2 percent to 75 percent. Reported rates of birth control use ranged from 0 percent to 46 percent, with the average being 10 percent (GBAPP, 1993).

Maternal Problems

Young mothers tend to experience poorer medical outcomes during pregnancy and delivery. In 1987, 13.5 percent of total teen births in Fairfield County experienced complications of labor and delivery, and 10.2 percent of total teen live births resulted in low-birthweight babies.

Teenage mothers are at high risk of not completing high school. Two-thirds of teenage mothers have not finished high school. Many of the adolescent fathers also drop out, sometimes to find a job to support their new families.

Teenage mothers are less likely to work than mothers who give birth in their twenties. One in three teenage mothers will have such low level reading and math skills that she will be able to get only low paying jobs, if she can obtain employment at all (GBAPP, 1993).

Fetal Outcomes and Problems

The risk of the baby dying in the first year of life increases as the age of the mother decreases below 20 years. Almost 6 percent of first babies born to girls under 15 years old die in their first year, a rate two to four times higher than for babies born to women in their early twenties.

An infant born to a teen is almost twice as likely to die in its first year of life as an infant born to a mother in her twenties.

In Connecticut, less than half of the pregnant teens receive first trimester care; nearly one-third of pregnant women in Bridgeport from 1981 to 1988 received late or no prenatal care at all and almost half received inadequate prenatal care. Inadequate prenatal care is directly related to higher perinatal mortality (GBAPP, 1993).

Conclusions

Prevention of adolescent pregnancy should have the highest priority — it is cost effective and successful. In both human and economic terms, it is less expensive to prevent pregnancy than to deal with its consequences.

Sexually active teens, both boys and girls, need the interpersonal skills, techniques and motivation to avoid pregnancy and to deal with issues of abuse and responsible social behavior.

Lack of sufficient affordable child care, housing, transportation and jobs; limited capacity of some programs; lack of accessible care during non-traditional hours;

inadequate drug counseling and rehabilitation; limited eligibility guidelines for financial assistance; lack of health coverage and few conveniently located services, act as barriers to needed services for pregnant and parenting teens.

There is no single approach or quick fix to solving all the problems of early unintended pregnancy and parenting. There continues to be a need for a comprehensive array of policies and programs that address the complex and controversial issues of adolescent pregnancy.

Male involvement is central to the solutions of adolescent pregnancy. The male's attitude, motivation and behavior are as central to the problem as those of his female partner.

Action Steps

- Advocate, at the local Board of Education, for a comprehensive family life and sexuality curriculum which includes information about sex, drugs and AIDS. A community council convened by local Boards of Education should be established to draft a plan to accomplish this goal.
- Support parent involvement through community parent organizations to ensure their participation in parenting education; support parent groups to increase their background information and enhance their capability in communicating well with children, and in providing a nurturing environment for the family.
- Hire community health educators with skills in the areas of pregnancy and adolescent development, drug abuse, sexual abuse and AIDS/HIV to enhance the capacity for adolescent wellness through the involvement of parents, students, educators and community health and social service providers.
- Promote a "one-stop-shopping" model for adolescents as a way to streamline service delivery and enhance utilization of services:
  - Improve access to medical care, especially hours that do not interfere with school/work, as well as free pregnancy testing with counseling; make available contraceptive services to all sexually active teens at low or no cost; and decrease delays to initiate appointments.
  - Provide medical care that is appropriate for the age and culture of those served, focusing on sexually transmitted diseases, responsible sexual behavior, and compliance with nutrition.
  - Stress psycho-social issues such as domestic violence, rape, promiscuity, self-esteem, parenting and inter-personal relations.
  - Develop a systemic plan to determine program effectiveness and consistency both within and between programs in terms of delivery of services and information systems management.
  - Establish/expand after-school, weekend and summer activities, including recreation, sports, human sexuality education, job opportunities and remedial education.

Report from the Bridgeport Regional Business Council on the Employment of Bridgeport Youth

Available data on employment for Bridgeport youth show that a high percentage of youth are working or receiving specialized training so they will leave school with marketable skills. These figures appear promising, but they do not adequately reflect the reality of job-seeking Bridgeport graduates.

According to data collected from Bridgeport students in 1992 by the Institute for Survey Research, 49 percent of middle school students, 65 percent of tenth and eleventh graders, and 81 percent of seniors have worked for pay outside the home. Twenty percent of middle school students, 28 percent of tenth and eleventh graders, and 52 percent of the seniors were working at the time of the survey. Thirty-two percent of ninth graders, 44 percent of tenth and eleventh graders and 65 percent of the seniors reported working sometime during the school year.

In addition, a survey of recent graduates conducted by the Bridgeport school district each year as required by the state of Connecticut indicates that 2.6 percent of the 1991 graduates were unemployed. A limitation of this survey is that it only reflects information provided by students responding to the survey. This matches the state average and compares favorably with the reference group's (the other major urban areas in the state) total of 3.7 percent unemployed. Nineteen percent of the 1991 graduates reported full-time civilian employment as compared to the 14.4 percent of the reference group.

Special Programs

Bridgeport is rich in special programs to prepare its students for college or the world of work. The recently developed magnet schools will soon produce graduates who will be more employable than graduates in the past who may have completed a general education program but still lacked the skills needed to secure employment. The magnet high schools now operating are Regional Aqua-culture School at Captain's Cove, Health Magnet at Harding High School and Business Magnet at Bassick High School.

Bridgeport students also have special services available to help them secure their first or second job:

- Placement services in each of the high schools operate through the Career Centers. In 1991-92, part-time staff at the three Career Centers placed 732 students in part-time jobs.
- The Bridgeport Contract, a jobs for graduates program in partnership with the Bridgeport Regional Business Council, provides assistance in preparation for and placement in a job after graduation. In 1992, there were 57 students who met the criteria. Of these, 45 were interested in entering

the work force. By January 1993, only 30 of the 45 were hired. These disappointing results have led to a planned re-evaluation of the program.

Trends

The following trends have become apparent and will be setting the tone for the years to come:

- Each year, a higher percentage of students are choosing to attend post-secondary study before entering the work force.
- Students not going on to further study and who have not participated in a special vocational program lack marketable skills and are having increased difficulty competing with other job seekers.
- Employers are looking to hire people with some work experience and express reluctance to hire students with no experience.
- Part-time placement services in the three high schools continue to serve high numbers of students despite the economic downturn.

Concerns

There are several trends and information gaps that must be addressed to improve the employability of Bridgeport graduates. These include the following:

- The loss of a manufacturing base in the community has meant the loss of job opportunities for unskilled high school dropouts and graduates.
- The economic downturn has resulted in a reduction in the number of jobs available to entry-level workers.
- There are increases in the level of skills required for all workers.
- There is increased competition for the few available jobs, as experienced workers are also seeking employment due to layoffs.
- There is a lack of services targeted to dropouts and disconnected youth.
- The perception of a lack of jobs and employment opportunities seems to be worse than the data support.

Goals

In order to improve the youth employment/employability process, a number of goals will have to be set including:

- A commitment to develop valid and reliable data bases to understand the dimensions of the current situation and to track the progress of strategies developed to improve this employability situation.
- The examination of existing opportunities and trends. This information will then be used to develop and implement community-wide strategies to address the issues and capitalize on emerging opportunities. This process should include parents and students.

Report on Education

A rich and powerful data base on children is being compiled and updated yearly for the city of Bridgeport. These data, compiled by several different sources, confirm that there are two Connecticuts: one rich and one poor. This economic dualism is reflected in the educational resources available to children in the urban center of Bridgeport, where the greatest needs are present. Despite the social and economic constraints in the city of Bridgeport, however, data also show that its children are performing better than their reference groups in Hartford and New Haven.

Compilation of Data

Bridgeport Futures and its partners are employing select school-based indicators of youth success as proxy measures for the community's plan to enhance the quality of life for its children. This effort to assess the impact of community-wide strategies to better the life outcomes of children is supported by the extensive data collection of Metis Associates, the Institute for Survey Research and the Center for Research in Social Policy.

The Student Cohort File, as compiled by Metis, includes information on 25,225 students in the Bridgeport School System for the past three academic years (1988/89, 1989/90 and 1990/91). These data collection activities are supported directly by The Annie E. Casey Foundation, and are also used as part of Casey's evaluation of the national New Futures Initiative.

In addition to these aforementioned data sources, the State of Connecticut Department of Education has also mandated the development of *Strategic School Profiles* for every school system in the state. This is a powerful local planning tool for not just the Board of Education, but the community in general.

The Bridgeport Board of Education is the principle partner in Futures' overall data collection and assessment. A comprehensive profile of children is emerging that can meet specific Board of Education and community-wide planning and problem-solving needs. During 1992 and 1993, two special studies were jointly undertaken by Futures and the Bridgeport Board of Education—a study of retention in grade and an evaluation of the effects of after-school programming at three middle schools. The results of these efforts will be used to examine and change existing policies and guide resource allocation.

The *Strategic School Profiles* speak to the reality within Connecticut, highlighting a definite dualism between rich and poor. This economic dualism is reflected in the

educational resources available to the children in the state's urban centers, where the greatest needs are present. The Profiles contain information by school on student needs, school resources, school performance and student performance.

The following are select system-wide characteristics based on the *1991/92 Strategic School Profile* for Bridgeport (Bridgeport Board of Education, 1992, pp. 2-3):

- Student breakdown by race/ethic group:
  - Hispanic
    8,393 (41.5 percent)
  - Black
    8,251 (40.8 percent)
  - White
    2,795 (13.8 percent)
  - Asian Americans
    734 (3.6 percent)
  - American Indian
    52 (0.3 percent)
- Only 60.3 percent of elementary students return to Bridgeport schools; almost 40 percent of students each year are new to the system.
- A total of 41.9 percent of students are from a home in which English is not the primary language.
- Free or reduced lunches are provided to 62 percent of the students. In 1992-93, this number was 71 percent (Huydic, 1992).
- Over 5,400 students receive compensatory education.
- The total expenditure per pupil of $6,462 falls short of the state average by almost $1,000.

Despite the social and economic constraints in Bridgeport, its children are performing better than their reference groups in Hartford and New Haven. Bridgeport spends less on administration and more on instruction than its reference cities. Measures of students' performance indicate that Bridgeport children have made gains in reading, math and language. The Metis Cohort Study supports the direction of these trends in student performance.

According to the Cohort data, Bridgeport's sixth- through eighth-grade students show improvement in each of the following: attendance, reading, retention, over age, suspension and dropout rates. (See Table 15.) The improvements in attendance, retention and suspension rates have been termed dramatic among middle school students. Bridgeport's high school students have also exhibited some improvements in attendance, over age, and dropout rates. The data also show that proportionately more high school students are being retained in grade and suspended out of school.

Dropout rates for Hispanic students were found to be particularly high, with over 55 percent of Hispanic students falling into the presumed "dropout" or "unaccounted for" categories. Black students experienced the highest levels of suspensions (33.2 percent school district vs. 39.2 percent in Bridgeport). Hispanic students were retained in grade in higher numbers (17 percent school district vs. 18.5 percent in Bridgeport).

Qualitative Survey Results

In addition to the quantitative data collection efforts, a survey of 3,012 students representative of middle and high school populations were surveyed by the Institute for Survey Research at Temple University during May and June of 1992. The qualitative responses of students provide valuable insight into the reality behind the statistics.

TABLE 15:
Change in status of six key variables, Academic Years 1988-89 and 1990-91.

Variable	1988-89	1990-91	Change
Attendance (Average Daily Attendance)			
Middle Grades	89.9%	92.0%	2.1 better
High School	87.4%	87.8%	0.4 better
Low Reading			
Middle Grades	33.3%	31.8%	-1.5 better
High School	NA	NA	NA
Retention			
Middle Grades	7.2%	4.8%	-2.4 better
High School	10.3%	11.4%	1.1 worse
Over Age			
Middle Grades	13.2%	13.1%	-0.1 better
High School	16.7%	16.5%	-0.2 better
Suspensions			
Middle Grades	14.7%	6.2%	-8.5 better
High School	18.1%	21.2%	3.1 worse
Total Dropout			
Middle Grades	18.9%	18.0%	-0.9 better
High School	26.7%	25.0%	-1.7 better

Source: Metis Associates. (1992).
1988-89 - 8,179 Children (4,307 Middle School; 3,872 High School).
1990-91 - 8,302 Children (4,488 Middle School; 3,814 High School).

Middle and high school students revealed the following about themselves and, by inference, their classmates:

- The majority of students expect to complete high school and obtain post-secondary education or training.
- Sixty percent expect to complete at least four years of college; the rate is somewhat higher for blacks and females, and lower for Hispanics and males. But behavior does not match expectation: Only 20 percent enroll in college prep or advance courses; only a fifth of all students spend at least five hours a week on homework.
- Half of middle school students perceive that fighting is often or always a problem; 25 percent of the students cite the carrying of weapons as a frequent problem.
- Use and sale of drugs or alcohol in or near the schools are considered to be infrequent problems by fewer than 15 percent of all middle school students.

The data being compiled about the educational performance of Bridgeport's children is not only a measure of the school system's performance, but that of an entire community that remains accountable for the quality of life it provides for children and families. The challenge ahead is to translate these discrete data elements into information that can be used to understand and change the manner in which children- and family-related policies and programs are implemented.

Goals for Improving the Quality of Life of Bridgeport's Children

"To create the conditions for child/youth success by bringing about lasting changes in policies, practices and funding which now stand as barriers to positive life outcomes for kids."

The statistics and information in this report card have been assembled to support the Bridgeport Futures Initiative Oversight Collaborative's articulation of short- and long-range goals for improving life outcomes for Bridgeport's children. These goals will allow Futures to measure progress of its long-range plan, "Bridges to the Future: A Strategic Plan for Bridgeport's Children." The goals of this plan call for improvements in the measures of children/youth success and in positive changes in the systems designed to work with children. This yearly *Bridgeport Report Card on the State of Our Children* will become an accountability mechanism for institutions and individuals responsible for children.

The goals to be measured are defined through two sets of input. The first is through the needs identified by the Oversight Collaborative and contained within the long-range plan. The other is through the broad set of goals as established for all New Futures cities by The Annie E. Casey Foundation, Bridgeport Futures' major funder.

As contained in "Bridges to the Future," the overarching goal of the Bridgeport Futures Initiative is: "To create the conditions for child/youth success by bringing about lasting changes in policies, practices and funding which now stand as barriers to positive life outcomes for kids."

The purpose of this report card is to enumerate the goals set by the Oversight Collaborative; show the direction and specific objectives for achieving them; and publicly report to the community the progress made in reaching the five-year goals.

Measures of Success

The Oversight Collaborative selected key measures of youth success to monitor their progress. Futures will track these measures by establishing a baseline reading from three years of historical data, and by monitoring the progress made over the next five years.

A Bridgeport Report Card: Current and Projected Yearly Goals*

	GRADE	1993		GOALS 1997
1. Improved school attendance	Needs Improvement	Elementary (K-8) High School (9-12)	92.7% 86.6% (Year to date 6/93)	95% 90%
2. Fewer retentions	Needs Improvement	Elementary (K-6) Middle School (7-8) High School (9-12)	5.2% 4% 10.2%	4% or less 3% or less 9% or less
3. Fewer suspensions	Needs Improvement	High School (9-12)	1,982 (In 92-93)	8% reduction in four years
4. Higher graduation rates	Needs Improvement	High School (12th graders)	69.7%	72% or more
5. Lower dropout rates	Needs Improvement	High School students	30.3%	28% or less
6. Fewer births to teens	Needs Improvement	Births to single women under 20	18%	9% or less
7. Lower level of youth inactivity/ unemployment	Needs Improvement	Teens not in school or work (16-19 years old)	13.5%	10% or less
8. Decreased substance abuse — current use/last 30 days	Needs Improvement	Marijuana Alcohol	13% 38%	10% or less of all High School seniors 30% or less of all High School seniors
9. Decreased teen violent death rates	Needs Improvement	Annually	13	Nine or less per 10,000 (15-19 years old)
10. Decreased juvenile delinquency referrals	Needs Improvement	Percent referred — Total number/ Total juvenile population	5%	3% of all juveniles (under 18) referred

Source: Available on request from Bridgeport Futures Initiative.

*Goals for "Better achievement scores" and "Fewer course failures" will be included in the next report card.

Systems Goals

By 1994, Futures will also begin measuring systems goals. The systems level goals identified in the long-range plan focus on seven areas that will measure change in the way institutions serve children. These measurements will track key spheres of institutional activity that support youth success by establishing a baseline in the current year and monitoring progress made over a five-year period.

Progress is not the responsibility of just one individual or institution. It is, instead, our collective responsibility to ensure new futures for our children.

The long-range plan identified the following systems areas for measurement:

- Extent of community-wide awareness of youth issues.
- Extent to which decisions are child/youth centered.
- Extent to which service collaboration and integration are present as measured by the system's ability to:

  — Create and sustain the political climate necessary to hold community institutions accountable for the status of children and families,

  — Reform public policies and practices, based on appropriate data about vulnerable children and their families, and

  — Build integrated, holistic human services, including education, for children and families.
- Extent to which resources are reallocated in accordance with children/youth needs.

*The education-related goals on the previous page are based on data collected by Metis Associates, currently under contract with The Annie E. Casey Foundation. Metis has compiled four years of cohort data on all students in the Bridgeport School System. Goals focusing on substance abuse are based on incidence and prevalence data compiled by the Regional Youth/Adult Substance Abuse Project. Additional data has been collected from the Connecticut Department of Public Health and Addiction Services, Department of Children and Families and Juvenile Justice System and Law Enforcement for teen pregnancy, suicide and juvenile delinquency referrals respectively.

CONCLUSION

The contents of this report describe what appear to be bleak prospects for the children of Bridgeport. Yet, there is one major factor that provides hope for the future—the children's own strength and resilience despite major social, environmental and economic barriers to their success. The adult community of Bridgeport must embrace the basic principles that every child can learn and should be healthy and safe. These two tenets should inspire all to immediate action.

The Bridgeport Futures Initiative, under the leadership of the Oversight Collaborative, has committed to mobilizing and supporting a community-wide effort to ensure that all children have the options and opportunities needed to build upon their innate capacities for reaching their full human potential.

By using a collaborative approach to problem solving and planning, Futures will increase the organized capacity of all sectors of the community to provide the environment that will support the developmental needs of children. This effort includes parents and youth as partners in the process. Futures' strategic plan, "Bridges to the Future," outlines major shifts and change strategies to be implemented by the Oversight Collaborative. These include the following:

- Futures' new Vision Statement addresses both youth outcomes and adult responsibility for providing the tools youth need to be successful.
- Futures will lead the process of bringing together diverse constituents. Its functions will be broadened to include establishing community awareness, identifying and solving problems, mobilizing resources, developing community capacity, and being publicly accountable for improving youth outcomes.
- There will be a city-wide focus on system issues affecting "all" youth in Bridgeport.
- The target population will be "all" youth of all ages and service delivery systems.

- System-level reforms will include: Create the conditions for youth success by bringing about lasting changes in policies, practices and funding patterns that currently are barriers to youth success; use funds under the direct control of the Oversight Collaborative to support the tools of change and stimulate improvements in services, but not necessarily to add to the supply.
- There will be a functional rather than a categorical staff organization consisting of: training/development, consultation and technical assistance, applied research and evaluation, community development, and community involvement.
- Futures will continue to examine the feasibility and desirability of creating a single "community collaborative for children," calling for the consolidation of some agencies and the structuring of "essential partnerships" with others.
- Futures will develop "essential partnership" agreements with at least the largest youth-serving agencies. With other planning/ advocacy groups, Futures will develop a "roundtable" mechanism to regularly include all social and health service providers in restructuring the service delivery system.
- The Oversight Collaborative will create a new "job description" and establish new membership, as well as form agreements outlining specific responsibilities and commitments.
- The Futures Institute will be developed as the "new" framework and legacy of the "old" Bridgeport Futures Initiative.

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